FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0501	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	08/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOUNT MEMORIAL TRANS CARE CTR	2320 EAST LAMAR ALEXANDER PKWY MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on August 11, 2013, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie McCadden

TITLE: Administrator

(X6) DATE: 8/27/13